TABLE 3—Distribution of Total Hours Devoted to Buddy Work by Satisfaction Status [number in category/number of respondents (percent)*]

# Hours per Week Devoted	Satisfied N (%)	Dissatisfied N (%)	Total N (%)
≤5 hours/week	7/19 (36)	12/31 (39)	19/50 (38)
6–10 hours/week	6/19 (32)	6/31 (19)	12/50 (24)
≥11 hours/week	6/19 (32)	13/31 (42)	19/50 (38)

*All percents are rounded to the nearest whole number; totals may not equal 100%.

5.1). Volunteers with 10 or less requests per week from their clients also reported greater satisfaction (prevalence ratio = 3.2; 95% ci = 1.5, 6.0). Buddies serving PWAs with more supportive relationships (other than buddy-client) in their lives were twice as likely to be satisfied in their work (prevalence ratio = 2.0; 95% ci = 0.8, 4.7).

Discussion

This study may be the first attempt to describe the work of AIDS volunteer programs such as the buddy program of Rhode Island Project/AIDS. Comparison of buddy/client and client/state AIDS case demographics suggest that minorities are underrepresented in these volunteer populations. While none of the volunteers responding to our questionnaire reported themselves as representing the Latino population, Rhode Island Project/AIDS' proportion of Black and Latino clients (25 percent)[5] is comparable with the state's proportion of Black and Latino cases (29 percent).[6]

This study describes the variety of services performed by buddy volunteers, and their interaction with the agency. Although there was considerable comparability between respondents and nonrespondents with respect to motivation for volunteering and providing support as buddies, we are cautious about generalizing the survey findings because the response rate was low.

The Buddy Program is a valuable, volunteer-based health care service that is critically needed by people with HIV (human immunodeficiency virus)-related illnesses. This description may stimulate increased appreciation of this service as well as promote an understanding of how to organize volunteers' efforts and support their needs.

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Epidemiology of Reported Cases of AIDS in Lesbians, United States 1980–89

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Abstract: National surveillance data for reported cases of acquired immunodeficiency syndrome (AIDS) were used to assess demographic characteristics and behavioral risk factors in lesbians. From June 1, 1980 through September 30, 1989, 79 women with AIDS reported sex relations only with a female partner; most of these women (95 percent) were intravenous drug users. Prevention of human immunodeficiency virus (HIV) infection in the lesbian community will require efforts to prevent and reduce intravenous drug use. (*Am J Public Health* 1990; 80:1380–1381.)

Introduction

Very little has been written on the epidemiology of acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection in the lesbian population. Two instances of female-to-female sexual transmission of HIV have been reported,[1,2] and there is some concern that the risk of infection in female homosexuals may be underestimated because of the lack of information about this population group.[3] This report describes various demographic characteristics and behavioral risk factors of lesbians with AIDS in the United States.

Methods

We used national surveillance data for 9,717 cases of AIDS in adult women reported to the Centers for Disease Control (CDC) between June 1, 1980 and September 30, 1989. Only those that met the CDC surveillance case definition for AIDS were included in our analysis.[4] AIDS patients were grouped according to their reported sexual behavior, using responses to the following two questions:

- "After 1977 and preceding the diagnosis of AIDS, did this patient have sexual relations with a male partner?"
- "After 1977 and preceding the diagnosis of AIDS, did this patient have sexual relations with a female partner?"

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Women who had sexual relations only with female partners were classified as lesbian, women who had both male and female sexual partners were classified as bisexual, and women who had only male sexual partners were classified as heterosexual. For women who were classified as lesbian, recorded data (e.g., sex, sex partners, mode of transmission) were confirmed directly with the reporting health departments to minimize misclassification and data entry errors. We excluded 1,242 women who could not be classified as lesbian, bisexual, or heterosexual because of incomplete responses to the above two questions. However, 90 percent of these women had a known risk for HIV exposure (intravenous drug use, heterosexual contact with a person at increased risk for, or known to be, infected with HIV, or blood transfusion).

Persons with AIDS were classified in a hierarchy of exposure categories according to their presumed means of acquiring HIV infection. Those with more than one possible means of acquisition were classified only in the exposure listed first in the hierarchy, by using the following sequence: 1) intravenous drug use, 2) receipt of blood products, 3) heterosexual contact with an HIV-infected partner (or having a specified risk for HIV), and 4) "no identified risk." The last category represents persons who had none of the other risk exposures above, and therefore could include women who acquired HIV infection through female-to-female sexual contact.

Results

As of September 30, 1989, there were 79 reported cases of AIDS in lesbians, representing 0.8 percent of all reported adult women with AIDS in the United States.

As shown in Table 1, most of the lesbians with AIDS (95 percent) were intravenous drug users (IVDUs). The remaining 5 percent acquired HIV infection through the receipt of blood or blood products. As with IVDU-associated AIDS in all women, most lesbian women with AIDS were younger (85 percent were less than 40 years old), Black or Hispanic (80 percent), and resided in the northeast (77 percent). There were 103 reported cases of AIDS in bisexual women. Most bisexual women with AIDS also were IVDUs (79 percent), 16 percent had sex partners at increased risk or known to be infected with HIV, and 4 percent had histories of blood transfusion.

We also compared the occurrence of reported opportunistic diseases among homosexual, bisexual, and heterosexual women with AIDS. The only notable difference was in the occurrence of Kaposi's sarcoma (KS). KS (including presumptive and confirmed diagnoses) was not reported in any of the homosexual females with AIDS but was reported in 9 percent (9/103) of bisexual females and 2 percent (167/8,293) of heterosexual females with AIDS.

TABLE 1—AIDS cases in Lesbians (June 1980-September 1989) reported in the United States

AIDS Cases	No. (%)
Exposure category	
IVDU	75 (95)
Transfusion	4 (5)
Age (years)	
13–19	0 (0)
20–29	19 (24)
30–39	48 (61)
≥40	12 (15)
Race/ethnicity	
White	15 (19)
Black	30 (38)
Hispanic	33 (42)
Other	1 (1)
Region	
Northeast	61 (77)
Midwest	0 (0)
South	7 (9)
West	3 (4)
Territories	8 (10)

Discussion

Lesbians represent a very small proportion of women with AIDS in the United States, and most cases are related to intravenous drug use. Prevention of HIV infection in the lesbian community will require efforts to prevent and reduce IV-drug use—the major and most direct means of transmission in this population.

Although there is no specific exposure category for female-to-female transmission, lesbians who acquired HIV infection from female-to-female contact would have been classified in the "no identified risk" (NIR) exposure category, of which there were none. Female-to-female transmission of HIV also could occur among bisexual females; however, only one bisexual female had no identifiable risk and was classified in the NIR category.

Although it is not possible to determine whether differences in the occurrence of Kaposi's sarcoma (KS) reflect differences in exposures, we also observed that among women with AIDS who reported sex with a *bisexual* man, 4.1 percent (20/493) had KS reported, whereas among women who did not report sex with a *bisexual* man, 1.6 percent (52/3162) reported KS. Moreover, the frequencies of reported KS were higher among homosexual (22 percent) or bisexual men (14 percent) than among heterosexual men (3 percent) (whose predominant means of HIV exposure was intravenous drug use). These patterns are compatible with the hypothesis that KS is a sexually transmitted infection that occurs in association with HIV infection and disproportionately affects homosexual and bisexual men.[5]

It is important to note that we used categories based on reported sexual behaviors, not on self-labeled sexual orientation. The labels "heterosexual" and "homosexual" do not always predict sexual behavior.[6] Our "lesbian" category does not necessarily represent women who identify themselves as lesbians, but more accurately represents women with AIDS who reported having sexual relations only with a female partner since 1977.

Although female-to-female transmission of HIV appears to be an extremely rare event, the occurrence of AIDS among lesbian and bisexual women indicates that women who engage in sex with other women can be exposed to HIV. Case reports of female-to-female sexual transmission of HIV[1,2] and the well-documented risk of female-to-male HIV transmission indicate that vaginal secretions and menstrual blood are potentially infectious and that mucus membrane (e.g., oral, vaginal) exposure to these secretions can potentially lead to HIV transmission.

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